STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001150	A. BUILDING: _____ B. WING _____	10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA OF THE WOODS	5610 NOLL AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit for for a State Residential Licensure Survey. Survey dates: October 9 & 10, 2013 Facility number: 001150 Provider number: N/A AIM number: N/A Survey team: Sue Brooker RD TC Virginia Terveer RN Census bed type: Residential: 9 NCC: 3 Total: 12 Census payor type: Medicaid: 7 Other: 5 Total: 12 Sample: 6 Villa of the Woods was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 10//13 by Lisa McColly	R 000		